Maternal Health and Nutrition in Tribal Areas

Report of the Fact-Finding Mission to Godda, Jharkhand

National Alliance for Maternal Health and Human Rights, India
and TORANG Trust, Ranchi

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20-23 November 2013

A Report

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National Alliance for Maternal Health and Human Rights, India
And
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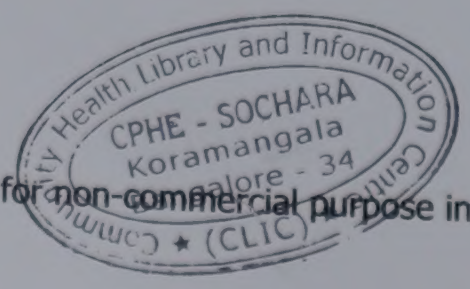

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Preface

The National Alliance for Maternal Health and Human Rights (NAMHHR) is an Alliance of 36 members from 14 states of India who are committed to attaining the highest quality of maternal health for marginalized women in India. NAMHHR members have been working for decades with issues of tribal women's maternal health in Barwani (Madhya Pradesh), Bharuch (Gujarat), Bilaspur (Chhattisgarh), Godda (Jharkhand) and Mirzapur (Uttar Pradesh), among others. NAMHHR engaged actively in seeking accountability on the issue of multiple deaths of tribal women during pregnancy and childbirth in one District Hospital of Barwani district (Madhya Pradesh) along with other civil society organizations and networks. Most recently a paper was published in Economic and Political Weekly (*Stairway to Death: Maternal Mortality Beyond Numbers*, Banerjee et al, EPW Aug 3, Vol XLVIII No. 31, 2013) that examined 23 maternal deaths occurring in one year among young, poor women mostly from tribal communities, including Particularly Vulnerable Tribal Groups (PVTG) in two blocks of Godda District (Jharkhand). This was followed by an article in The Hindu (*Where Women Face Death During Childbirth*, 9 Aug 2013) which led to a *suo motu inquiry* by the National Human Rights Commission to the Government of Jharkhand. (http://nhrc.nic.in/disparchive.asp?fno=12978 Ref.1177/34/9/2013)

The Alliance has resolved to develop greater understanding of the condition of maternal health in tribal areas. As a first step, NAMHHR felt that it would be useful to conduct a Fact-Finding Mission (FFM) to district Godda in Jharkhand to explore not only the maternal health situation but also the impact of related social determinants of health. It is hoped that this brief report will provide some insight into the conditions under which women from under-served tribal areas go through pregnancy and childbirth, and that the recommendations will prove useful for policymakers and programme managers.

This report is especially relevant now that the Government of India has set up two committees to provide recommendations on the status of tribal communities in India and how service delivery can be improved in these areas. A High Level Committee has been constituted by the Prime Minister's Office (PMO) (ID No. 560/51/C/15/2012 – ES.2 dated 14 August 2012) to prepare a report on the socio-economic, health, and educational status of tribal communities of India. Submissions have been requested by the Ministry of Tribal Affairs, asking for policy recommendations as well as effective outcome-oriented measures to improve service delivery. Additionally, the Ministry of Health and Family Welfare (MOHFW) has constituted an expert committee headed by Dr. Abhay Bang (SEARCH Gadchiroli) to better address healthcare challenges of tribal populations, so that services for them can be appropriate, accessible and of high quality.

A preliminary draft of this report has already been shared on 17-18 February 2014 with the senior health officials of the Government of Jharkhand, including the Hon. Minister of Health, the NRHM Mission Director, the Director of Health Services, Officer in Charge of Reproductive Child Health, and the Consultant for Maternal Health in UNICEF. The officials appreciated the efforts of NAMHHR to highlight the situation of tribal women, acknowledged

some of the shortcomings of the current system, and also mentioned the challenges and barriers they faced.

The Fact-Finding Mission team would like to acknowledge the help and cooperation it received from the senior officials of the Government of Jharkhand, as well as from all of the programme managers and service providers they met during the visit.

We also acknowledge the support of all of our partners within the National Alliance for Maternal Health and Human Rights, whose encouragement as well as practical inputs enabled the team to proceed with confidence about the collective ownership of the findings. We would like to especially acknowledge the contributions of NAMHHR partners in Jharkhand before, during, and after the visit.

We gratefully acknowledge the support in report writing provided by NAMHHR Secretariat staff members, as well as editorial contributions from staff at Centre for Health and Social Justice and SAHAYOG.

Last but certainly not least, we salute the patience and hospitality of the women of the rural communities we visited, and express our profound gratitude to all of them for sharing with us their experiences of maternal health and nutrition services.

In solidarity,

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Abhijit Das
Devika Biswas
Vasavi Kiro
Soumik Banerjee
Ajay Lal and
Md. Sarfraz Ali

Members of the NAMHHR Fact-Finding Mission to Godda, 20-23 November 2013

GLOSSARY

List of Acronyms and Abbreviations

AAY	Antodaya Anna Yojana , a scheme to provide subsidised food grain to the poorest families in India
Addl. CMO	Additional Chief Medical Officer
AGCA	Advisory Group on Community Action formed under the National Rural Health Mission (NRHM) of 2005-12
AHS	Annual Health Survey done in India in recent years in selected states with poor health indicators
ANC	Ante-Natal Care
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist, a member of a community volunteer cadre formed under the NRHM
AWC	Anganwadi Centre providing supplementary nutrition to pregnant and lactating women, young girls and children
AWW	Anganwadi Worker who runs the Anganwadi centre
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy (non-allopathic forms of medicine practised in India)
BDS	Bachelor of Dental Surgery
BMC	Bihar Medical Collage
BMI	Body Mass Index
BP	Blood Pressure
BPMO	Budget, Planning, and Management Officer posted in the Community Health Centres
C- Sections	Caesarean sections
CHC	Community Health Centre
CS	Civil Surgeon of the district
DC	District Collector
DH	District Hospital
ECL	Eastern Coalfields Limited
EmOC	Emergency Obstetric Care
EMRI	Emergency Management and Research Institute that manages the 108 Ambulance service
EPW	Economic and Political Weekly
FFM	Fact-Finding Mission
FGD	Focus Group Discussion

FLW	Frontline Worker
FRU	First Referral Unit
HEDAN	Hodopathy Ethno-Medicine Doctor's Association of India
HSC	Health Sub-Centre
ICDS	Integrated Child Development Services
IEC	Information, Education and Communication
IFA	Iron Folic Acid
JSSK	Janani-Shishu Suraksha Karyakram
JSY	Janani Suraksha Yojana
MCH-Bhagalpur	Bhagalpur Medical College Hospital in Bihar, a neighbouring state of Jharkhand
MCH	Mother and Child Health
MCTS	Mother And Child Tracking System
MD	Mission Director of NRHM
MDM	Mid Day Meal provided in schools
MDR	Maternal Death Reviews
MGNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MOIC	Medical Officer in Charge
MOHFW	Ministry of Health and Family Welfare
NAMHHR	National Alliance for Maternal Health and Human Rights
NBSU	Newborn Sick Unit
NGO	Non-Governmental Organization
NMBS	National Maternity Benefit Scheme
NRHM	National Rural Health Mission
OBC	Other Backward Class
OPD	Outpatient Department
PDS	Public Distribution System
PHC	Primary Health Centre
PMO	Prime Minister's Office
PPH	Postpartum Haemorrhage
PVTG	Particularly Vulnerable Tribal Groups
RCH	Reproductive and Child Health
RKS	Rogi Kalyan Samiti, literally the patients' welfare committee. This is a hospital management committee set up for all government hospitals
RMP	Registered Medical Practitioner
RSBY	Rashtriya Swasthya Bima Yojana, a health insurance scheme that provides coverage for hospitalization up to Rs 30,000 per family
SBA	Skilled Birth Attendant
SHG	Self-Help Groups, usually groups of women in the village for savings and micro- credit
SNP	Supplementary Nutrition Programme
TBA	Traditional Birth Attendant
THR	Take Home Rations usually given in the Anganwadi centres

TT	Tetanus Toxoid
UNICEF	United Nations International Children's Emergency Fund
VHND	Village Health & Nutrition Day set up under the NRHM
VHSC/ VHSNC	Village Health and Sanitation Committee or Village Health, Sanitation and Nutrition Committee set up under the NRHM

Translation of Hindi/local terms

Basa	Accommodation
Daal	Lentil
Dai/Dom/ Dagri buri	Traditional Birth Attendant
Doli	Stretcher or Palanquins
Gram Sabha	Local self-government institution at the village or small town level in India
Haat	Weekly market
Kala Bukhar	Kala-azar or visceral leishmaniasis
Kuchha	Temporary
Mamta Vahan	A round-the-clock transport facility available at Panchayats to bring rural pregnant women to health centres for institutional deliveries
Ojha	Traditional shaman or herbal practitioner
Panchayat	Village assembly
Pradhan	Elected head of village Gram Sabha/Local Council
Sahiya	Means "companion" and stands for ASHA (Accredited Social Health Activist) equivalent in Jharkhand
Sevika	Anganwadi worker in Jharkhand
Tola	Hamlet

I. Background to the area

A. A profile of Jharkhand and Godda district

Jharkhand state, the 28th state of the Indian Union, was brought into existence on November 15, 2000 by the Bihar Reorganization Act. Forests and woodlands occupy more than 29% of the state, which is amongst the highest forest cover in India. The region has mostly hills and forests inaccessible in many places, and also has large deposits of mineral wealth. The tribes of this state include Primitive Tribes and other tribal groups, many of whose lifestyles have remained the same over hundreds of years, barring the last few decades.

- **Primitives Tribes:** Asur, Birajia, Korba, Mal Paharia, Parahiya, Sabar (Hill Kharia), and Sauriya Paharia.
- **Other Tribes:** Banjara, Bathudi, Bedia, Biga, Binjhia, Chero, Chik Baraik, Gond, Gorait, Ho, Karmali, Khadia, Kharwar, Khond, Kisan, Kora, Lohra, Mahali, Munda, Oraon and Santhal.

Godda district is part of the **Santhal Parganas division of Jharkhand,** which is dominated by tribal communities. The district has eight blocks with 2,304 villages. Some of the blocks have rich alluvial soil for agriculture, good roads, and are populated by Other Backward Class (OBC), minorities and few tribal communities. Other more backward blocks like Sundarpahari have hilly terrain, a high proportion of the more marginalized tribal

communities like the Pahariyas, and most habitations are not connected to the few roads that exist.

Table 1: Basic demographic data of Jharkhand and Godda district

Sl.No	Indicators	Jharkhand	Godda
1	Total Population (Census, 2010-11)	32,966,238	32,966,238
2	Crude Birth Rate (AHS* 2010-11 Jharkhand)	23.7	23.6
3	Crude Death Rate (AHS 2010-11 Jharkhand)	6.1	7.2
4	Total Fertility Rate (AHS Bulletin, 2011-12 Jharkhand)	3.1	3.2
5	Infant Mortality Rate (AHS 2010-11 Jharkhand)	41	64
6	Maternal Mortality Ratio[1] (AHS Bulletin 2011-12 Jharkhand)	27	-
7	Sex Ratio (AHS 2010-11 Jharkhand)	942	923
8	Female Literacy Rate (%) (Census 2010-11)	56.21	44.90
9	Scheduled Caste Population (Census 2010-11)	3,985,644	115,567
10	Scheduled Caste Population (%) (Census 2010-11)	12.09	8.81
11	Scheduled Tribe Population (Census 2010-11)	864,5042	279,208
12	Scheduled Tribe Population (%) (Census 2010-11)	26.22	21.29

*Annual Health Survey (AHS)

B. Description of social groups in the area

Sundarpahari block has an entirely rural population, with 79% belonging to the Scheduled Tribe category. Of the 208 villages in Sundarpahari, 125 villages are inhabited by Particularly Vulnerable Tribal Groups (PVTGs). Nearly 50% of land in Sundarpahari block is forested and hilly. The literacy rate in Sundarpahari is 27%, while the primary occupation in the area is subsistence agriculture. These areas see high morbidity and mortality owing to the absence of accessible, quality health services coupled with a lack of awareness regarding health and nutrition among the population (Banerjee et al 2013).

Sundarpahari is home to Paharia and Santhal tribes. The Paharias are the original inhabitants of the area, with a population of 13,169 (Census 2001). These Primitive Tribal Groups (PTGs)[2] are some of the most disadvantaged in the area, residing on hilltops with abject poverty, inaccessibility, low literacy levels and poor nutritional status. These villages are malaria-endemic and other infectious diseases also abound. Godda district has an Infant Mortality Rate (IMR) of 64 as compared to Jharkhand with 41 (AHS 2010-11); the neo-natal mortality rate is about thrice that of the state average.

The Santhals, largely residing on the plains, carry out paddy cultivation and Tasar sericulture, and collect other forest produce. The Paharias practice shifting cultivation of pulses and millets on the hill slopes and are also involved in collection and sale of forest products. Agriculture is rain-fed, none of the tracts in the hills are irrigated and collection

[1]Maternal Mortality Ratio (deaths per 100,000 live births) has been estimated at 261 in Bihar and Jharkhand for 2007-09 by the government (Special Bulletin on Maternal Mortality in India 2007-09, Sample Registration System, Office of the Registrar General, India)

[2]Jharkhand has 9 PTGs out of which two of the largest groups- Saoria and Mal Paharias reside in this area

from commons has also dwindled with the reducing forest cover, thus making livelihoods particularly vulnerable.

The Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA) is almost a non-starter in the area, and due to operational difficulties and lack of awareness, large numbers of families still do not have job cards. The complex procedure of payment makes the Paharias averse to this program, pushing them further into poverty and migration to West Bengal, the Northeast, Gujarat, Mumbai, and Jammu and Kashmir.

The majority of Pahariya households are able to grow about half of their total food requirement on their own farms. This is reflected in terms of extreme malnutrition rates[3] amongst children and even adults. Antodaya Anna Yojana (AAY) is the only government program that functions to some degree of satisfaction, though there are many deserving households that are still to get AAY cards. Public Distribution System (PDS) shops are located far away from the villages (especially in the hills) and are marked by unfair practices of weights and measures, discrepancies and irregular and delayed grain allotment. Old age pension schemes like Annapurna, etc., are also marred with corrupt practices, delay, quota system and faulty identification, thus keeping some of most destitute people outside the purview of food schemes. These are the people who usually suffer from starvation deaths.

C. Maternal health in Godda district of Jharkhand

The following tables (2-4) provide the AHS 2010-11 data on the situation of maternal health services in Godda with comparisons to Jharkhand as a whole. It is clear that antenatal services are unable to detect high-risk signs since less than a third of all women were tested for high blood pressure and hardly one-fifth for haemoglobin. Moreover, in Godda, data indicates that **childbirth at home is 75.2%,** which is much higher than the rate of institutional delivery (24.4%). The rate of C-sections performed at government and private hospitals is also remarkable, since women are clearly accessing emergency obstetric care (EmOC) on personal payment outside the state health facilities.

[3] Surveys were conducted by S. Banerjee and others across 21 Integrated Child Development Services (ICDS) centres during National Health (NH) Days in Paharia areas in 2008 - 56 % of Paharia children are underweight with 26% in severe malnourished conditions, almost all women are anemic and 67% of women have Body Mass Index (BMI) below 18.

Table 2: Details of Antenatal Care in Godda district, Jharkhand

Antenatal Care (ANC) indicators (all figures in percentage)	Godda	Jharkhand
Currently married pregnant women aged 15-49 years registered for ANC	43.4	66.1
Mothers who received any antenatal check up	67.4	86.1
Mothers who had antenatal check up in 1st trimester	42.1	56.3
Mothers who received 3 or more antenatal check ups	29.1	56.3
Mothers who received at least one tetanus toxoid (TT) injection	66.7	85.7
Mothers who consumed Iron Folic Acid for 100 days or more	9.8	15.1
Mothers who had full antenatal check up	9.7	13.1
Mothers who received ANC from government source	19.4	19.2
Mothers whose blood pressure (BP) was taken	30.8	52.6
Mothers whose blood was taken for haemoglobin (Hb)	21.4	36.9
Mothers who underwent ultrasound	12.0	19.2

Table 3: Delivery care in Godda district, Jharkhand

Delivery Care indicators (all figures in percentage)	Godda	Jharkhand
Institutional delivery	24.4	37.6
Delivery at government institutions	15.6	16.0
Delivery at private institutions	8.5	20.8
Delivery at home	75.2	62.0
Delivery at home conducted by skilled personnel	35.3	24.7
Safe Delivery	42.5	47.1
Caesarean out of total delivery taken place in government institutions	7.0	8.6
Caesarean out of total delivery taken place in private institutions	27.6	29.0

Table 4: Postnatal care in Godda, Jharkhand

Postnatal care indicators (all figures in percentage)	Godda	Jharkhand
Less than 24 hrs stay in institution after delivery	50.1	42.5
Mothers who received postnatal check up within 48 hrs of delivery	51.4	59.1
Mothers who received postnatal check up with in 1 week of delivery	52.6	64.0
Mothers who did not receive any postnatal check up	45.7	34.4
Newborns who received check up within 24 hrs of birth	44.5	55.9
Mothers who availed financial assistance for institutional delivery under JSY in government facilities	71.6	49.9

Source: Annual Health Survey 2010-11, Fact Sheet. Vital Statistics Division, Office of the Registrar General & Census Commissioner, India, www.censusindia.gov.in

II. Methodology of the Fact-Finding Mission

The Fact-Finding Mission (FFM) was set up on behalf of NAMHHR as a response to the high number of maternal deaths reported by the NAMHHR member in Godda.

A. Objectives and composition of the FFM team

The objectives of the Fact-Finding Mission were as follows:

- To develop a greater understanding of the condition of maternal health in tribal areas of Godda district by exploring health services and related determinants such as nutrition.
- To explore alternative strategies that would be effective for maternal and child health and nutrition in tribal areas.
- To seek answers to questions relating to service provisioning of the responsible line-departments - including the provisions that exist to tackle severe anaemia among tribal women and girls.

Based on interest and availability of the dates (20-23 November 2013), the team included NAMHHR members, experts as well as newer allies (TORANG Trust linked with the Hodopathy Ethno-medicine Doctors' Association of India-HEDAN) who could contribute significantly to the process. The Fact-Finding Mission included the following members:

1. Dr. Abhijit Das, Director, Centre for Health and Social Justice (New Delhi) and Member, Advisory Group on Community Action (AGCA) of National Rural Health Mission (NRHM)
2. Ms. Jashodhara Dasgupta, Coordinator, SAHAYOG (Lucknow); Convenor, NAMHHR; and former Member, High-Level Expert Group of the Planning Commission (Government of India) on Universal Health Coverage
3. Ms Vasavi Kiro, TORANG Trust and HEDAN; former Member, State Women's Commission, Jharkhand
4. Ms Devika Biswas, HealthWatch, Bihar & Jharkhand, independent activist working on health and gender issues
5. Mr Ajay Lal, (formerly of SATHI Pune) activist working on reproductive rights among tribal communities of Madhya Pradesh
6. Mr Soumik Banerjee, independent researcher investigating maternal mortality among tribal communities in Sundarpahari block of Godda, Jharkhand
7. Md. Sarfraz Ali, field worker with EKJUT, working on maternal health and other issues in Godda, Jharkhand

B. Information to the government of Jharkhand

A formal letter from NAMHHR was sent to the State Mission Director, NRHM Jharkhand requesting him for an appointment. On the evening of 20th November, two members of the FFM team met the State health department officials, as the Mission Director (MD) was busy. The FFM members met Dr. Sumant Mishra, Director of Health Services, Jharkhand, and informed him about the context and purpose of the FFM. Dr. Mishra assured all possible support of the health department and immediately connected the team members with Dr. Pravin Ram, the Civil Surgeon in Godda district, on the phone. Upon return from Godda, Dr. Abhijit Das once again met the Director to debrief him about the visit.

After returning from Godda, some of the FFM team members met the Minister of Health, Government of Jharkhand, Shri Rajendra Prasad Singh, on 23rd November 2013. He was informed about the FFM, and during the brief meeting the team members gave him a summary of the key findings and three major recommendations. He expressed interest in the report and promised to look through it once it was complete.

C. Field work and respondents

The FFM team spent two days in Godda (21-22 November) and visited three villages as well as one Community Health Centre (CHC), one First Referral Unit (FRU) and the District Hospital. In some cases the FFM team members split into two sub-groups to ensure greater coverage (see **Annex 1** for details of the respondents at each site).

The block CHC at Sundarpahari was visited fairly late in the evening to assess the presence of staff; however it emerged that the health workforce in all of Godda district had been alerted to the presence of the FFM and so the staff was present even at the late

hour. The list of health officials and health workers that the FFM interacted with are given in **Annex 1.**

The three villages visited were selected by the local guide Soumik Banerjee on the basis of varying distance from the block CHC, as well as different accessibility to roads and different tribal communities. Within the villages, the team conducted focus group discussions and interviews as follows:

Hamlet A of Village X: 35 km from block CHC, accessible by *kuchha* (temporary) road in good weather	✓ Focus Group Discussion (FGD) was done in the courtyard of a house with a group of Santhali women. Participants included four women who had children less than two years, mother-in law of a woman with a year-old baby, and one pregnant woman. Some older women were also present. ✓ The village Sahiya and a local dai (traditional birth attendant) was also interviewed
Hamlet B2 of Village Y: approx. 20 km from block CHC by metalled road, after which about 20-30 minutes walk through forest.	FGD was done in the centre of the hamlet with a group of Saoria Pahariya women including those who had given birth in the last year and a half. But during the discussion, community men, older women and children were all present
Hamlet C2 of village Z	✓ FGD was done with a group of women of the Mal Pahariya tribe, including four women who had recently delivered, as well as other women. The FGD was held in the courtyard of the house where there had been a maternal death some months ago, and the mother-in-law was present. An interview was done with the Santhali village Pradhan

D. Question guide

Before the FFM travelled to Godda, there was a draft question guide sent out to all members for comments. This was further discussed among some of the FFM members as well as NAMHHR member Kalyani Meena at Ranchi on 20th November, and some changes were made.

In addition, NAMHHR member Kalyani Meena organized a half-day meeting of the FFM team with civil society organizations and activists on 20th November in Ranchi to inform them about the FFM and to discuss the possible areas for investigation. Their suggestions were added to the question guide (see **Annex 2** for minutes of civil society meeting).

E. Limitations of this FFM report (and methodology)

We were a small team of four people from outside the area and two from the same district. There are several details that we may have missed as we are not familiar with the context. Additionally there are limitations to such a "fact-finding" approach that prevent us from obtaining in-depth information on the local culture and traditions regarding health, medical practices and customs.

We worked through translation, and our translators knew Santhali but were not fully versed in Pahariya dialects. We required more information about community beliefs and practices around marriage and reproduction, and about how the community managed care in pregnancy, childbirth and the post-partum stage. Much of this information was difficult to obtain during the focus group discussion. Moreover, our local guides/translators were both men, and there may have been limits to how much women would convey to them regarding sexual and reproductive issues.

We hope that despite the limitations, this report will lead to further inquiry and investigation into the nature of health-seeking behavior by tribal communities, towards providing more appropriate and acceptable maternity care.

III. Findings

The major findings are given below under these categories:

A. The place and the people
B. Current status of health services observed
C. Challenges identified
D. Plans of health department

Section A - The place and the people

i. Distance, communications and seasonal access

The Sunderpahari block comprises of hilly terrain and valleys, and public transportation is almost non-existent through the day. Many settlements are not on the road and can be reached only after a walk in forests or up a hillside. The hamlets of particular villages are scattered, and may be separated by hills, streams or forests. The roads or paths that connect them may not be usable during the rainy season.

For example, in Revenue Village X which is 35 km from the district headquarters, the approach road to Hamlet A is partly metalled but soon degenerates into 3-4 km of very bad road. To enter this village one has to cross part of Pakur district on Gumani River. Within the village, the only road is a clay track which is inaccessible during the rainy season. This small Revenue Village with a population of 700, comprising mostly Santhals, is scattered over hamlets as listed below, and it is therefore not surprising that the coverage of services is very patchy:

- ✓ Tola (hamlet) A where the *Sahiya* lives
- ✓ Tola P where Anganwadi Centre (AWC) is located and the Auxiliary Nurse Midwife (ANM) occasionally visits (it is this Hamlet in which the village headman or Pradhan, resides)
- ✓ Hamlet N where the Anganwadi Worker (AWW, or *Sevika* in Jharkhand) lives
- ✓ Tola M

The Health Sub-Centre (HSC) is located in Rampur, which is across the River Gumani, and there is no bridge for the villagers to cross when the river is swollen during the monsoons.

The village B2 of the Revenue Village Y offered another example of this, with two hamlets occupied by Saoria Pahariya tribal communities. The B1 Tola is 1200 feet up the hill, which means a 6 km walk through steep walking trails. Both the frontline workers - Anganwadi Sevika and *Sahiya* - are located in B1, therefore all the information and services are available there and seldom reach the B2 hamlet, which has only 18 households and 100 inhabitants.

The team found that, in contrast to Sunderpahari block, Mahagama has a very good approach road and is located in the plains, which have very fertile land as well as a coal mine at Lalmatia run by Eastern Coalfields Limited (ECL). The population of this block mainly consists of minorities and OBC, and is only about 10-15% tribal communities.

ii. Castes and sub-tribes

Although Sunderpahari is considered a tribal block, the population is not homogenous. The various tribes and sub-tribes have clear demarcations and hierarchy among themselves, and usually inhabit separate hamlets. In terms of outreach workers, this can lead to access issues, as the local health care worker may belong to a particular community and refuse to reach out to the women who live in another hamlet, thereby depriving them of information about entitlements and services. For example, although the Kumarbhag Pahariya are seen officially as part of the Mal Pahariyas, the Mal Pahariya villagers of Hamlet C1 cannot access the services of the *Sahiya* because she lives in the other hamlet and is a Kumarbhag Pahariya.

Section B - Current status of health services observed

i. Village level

Jharkhand government is implementing the National Rural Health Mission of the Government of India with some local changes. The Accredited Social Health Activist (ASHA) system has been locally adapted to the *Sahiya* system, with some concessions about the minimum educational qualifications required. The *Sahiya* programme has also seen some innovations, with more being planned to address the special situation in hilly and remote areas of these tribal-dominated regions.

Given below are the narratives that the team heard in the villages, including experiences of the women who had been pregnant within the last year, and the *Sahiya* of one village.

✓ Tola A[4] of Revenue Village X (connected by un-metalled road)

Revenue Village X is 35 km from the District Headquarters, and 15 km from the CHC. Following the team's visit, there was a maternal death in one hamlet of X (28 November 2013) as follows – a non-literate Santhal woman aged around 35 years died at the end of her sixth pregnancy when there was a retained placenta after birth followed by heavy bleeding. A local Registered Medical Practitioner (RMP) was called in, and charged Rs 600 for his treatment; however, she soon lost consciousness and passed away.

[4] We are grateful to Bahamayi for providing her courtyard for the FGD, and for Mariyam's help with translation

➢ During the focus group discussion in A hamlet of X, it was found that they are clearly not aware of their health and nutrition entitlements. Though most knew about the Mamta Vahan[5] except one, no one called for it, and all deliveries took place at home, assisted by community and family members (except in one case by an RMP). There is no post-natal care provided. Women are not aware of Village Health and Nutrition Day (VHND) for health check-up; no one got any antenatal care; only got some Take-Home Rations (THR) three times in 9 months with less than the prescribed quantity. Even though child immunization is done at the AWC, ANC is not provided.

➢ Srimati Soren, complicated labour: Srimati is a Santhal woman in her twenties living in X, mother of three children. She had her last child about a year ago, but did not receive any ANC, Iron Folic Acid (IFA) or Tetanus Toxoid (TT) injection. She was asked to visit the Health Sub-Centre at Rampur, and did go there but did not get any services as the ANM was not available. During her labour she had bleeding and prolonged labour pain over two days, so Srimati needed special help from the RMP and a "*Dom*" (Dai or Traditional Birth Attendant). The local RMP gave her seven injections before she finally delivered the baby at home. The RMP also gave her another five injections and some tablets after delivery. She had no knowledge about free services at the hospital like Janani Suraksha Yojana (JSY) or Janani-Shishu Suraksha Karyakram (JSSK) and says that she did not try going to a hospital as they did not have enough money. Neither the *Sahiya* nor the ANM had informed her about free maternal services. Although she herself did not get ANC, her child has been vaccinated and has a Child Immunization Card.

➢ As the Anganwadi Center (AWC) is located at Tola P (about three-fourths km away), the women of her hamlet are not called on the days of THR or VHND. A few times, seeing others going to the AWC, Srimati also went and got THR (consisting of approximately 100g sugar, 1 cup soya bean chunks, and about 1kg rice). She got this thrice, but does not know how much THR she is entitled to receive. She stated she was not aware of the various entitlements that she was entitled to receive. She suffered from malaria and her child also suffered from brain (cerebral) malaria; and she sought treatment for both from the RMP.

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[5] A round-the-clock transport system available at Panchayats to bring rural pregnant women to health centres for institutional deliveries

➢ Other women of this hamlet of A have similar narratives: Fulmumi Soren, Anita Soren (whose child is a year and a half) had their childbirth at home with no ANC or assistance from health service providers. Sabina Marandi said she was assisted by her elderly neighbours. The *Sahiya* did not tell them about any benefits/entitlement or counsel them about nutrition. There is no TBA (called *Dagrin Buri* by Santhals) alive but some women of the community like Bahamayi and others do assist their neighbours during childbirth.

➢ Regarding availability of the Mamta Vahan in A Tola, Talabati Murmu (who also did not get any ANC) did hear about the Mamta Vahan and called for it when she was in labour. But before it could reach her, she had already delivered the child at home so the vehicle returned without her. However, she got Rs. 1650 as JSY money, got her child vaccinated and received a mosquito net at the AWC. Somehow Talabati seemed to have accessed at least a few of her entitlements.

✓ **B2 hamlet in Revenue Village Y (20 minutes walk from the metalled road through forests and fields, not electrified)**

➢ Surajmani, complicated labour: One of the women, Surji (Surajmani), talks about her complicated childbirth; she was in prolonged labour for three days. Finally the family called in the *Dom* TBA from neighboring Phulwaria. She helped the woman to deliver, but had to be paid Rs 2000 (an exceptionally large payment). When asked why they did not transfer the woman to the health centre, the villagers looked surprised, since obviously no one has a vehicle here. Hiring one would be too expensive. No one knows about the Mamta Vahan, and anyway, no one has a mobile phone since there is no electricity in the village. The road is almost half an hour away through dense forest, so they didn't think it was feasible to use it.

➢ In the group there are five women who have recently gone through childbirth, all of whom delivered at home. None of the women have ever received any health services. They do not have much faith in the Sundarpahari CHC, alleging that *"you only get tablets there, no injections."*

➢ The villagers said that the ANM had not visited this village in many years. Some specified that it had been four years since she had come. The women say they would like someone better skilled to help out with childbirth, not what the present Dai offers. They want treatment for problems during pregnancy; they do want functioning Anganwadi centres and distribution of bed-nets against mosquitoes. Everyone in the village has suffered from malaria. One of the women, Chandi, had malaria during pregnancy, and survived with some herbal medicines.

➢ The Anganwadi Centre worker, Sevika does inform them when she has a stock of THR but usually it is once every two or three months. Two of the women, Surji and Maisie, have never received any THR during pregnancy or after birth; Bamdi got THR a few times and Marie got it twice during pregnancy and four times after delivery. Surji adds that she did get Rs 500 after her childbirth (the amount from the National Maternity Benefit Scheme

NMBS). The usual THR includes around a kilo of rice, about one glassful of *daal* (lentil) and some soya-bean chunks.

- The PDS system works and they do access their rations from the shop seven kilometers away. On the 30th of each month they receive free rations of 30 kg of rice, and all of them have the ration card for PVTG.

- None of the children have ever received any immunization in the entire village, not even polio drops. The children apparently all attend school in Phulwaria, but no one really knows their ages. One of the boys, Pilar, speaks some Hindi and goes to school, and has reached Class Three. He is an adolescent and has been married for four years.

✓ **Hamlet C2 of Z Revenue Village (approx. 40 minutes walk uphill, through footpaths across fields; not electrified, some solar lighting)**

- Four women with small babies joined the meeting. Sukurmoni's youngest is 4 months, Parvati's is 9 months, Kalavati's is one year old, and Sunita's is 3 months. None of the women or children have ever received services from any health provider. They have never been to a hospital, nor been immunized; not even against polio.

- Women of this tribe are not provided any family planning services, as there is a widespread notion that the government forbids its workers to offer contraceptive services to the dwindling Pahariya tribe since it is a PVTG. This has resulted in frequent/ unintended pregnancies, as the example of Sukurmoni shows. Her four children are aged seven, five, four and four months. The other two young women have three children each: Parvati's and Kalavati's children were born three years apart.

- They do know there is a *Sahiya* in the other hamlet C2 Tola but she is Kumarbhag Pahariya. She gave them the Mother Child Health (MCH) Card a year ago, but the cards were given after the child was born. She has never given them any medicines.

- The Anganwadi Sevika lives elsewhere in village C3, and she apparently does not call them for the Supplementary Nutrition Programme (SNP). However the women seem to have sporadically received some THR during or after pregnancy: while one did not get any rations at all, another woman got it just once, and two others got it a couple of times. They reported that the THR included around a kilo of rice, 100g of *daal*, 150g of sugar, and 150g of Soya chunks. The only thing that seems to be reaching this community is the PDS ration; all of them have the ration card and get 35 Kg (*sic*) of rice for free each month.

- Most women have had malaria in this village; Sukurmoni had it when she was pregnant, but was cured by herbal medicines from the local *Ojha* (traditional shaman or herbal practitioner). They had received bed-nets for mosquitoes, but that was long ago and now they are all torn. The local RMP does come to treat villagers for malaria, but charges Rs 1000-1500, which is usually not spent on women.

A Case Study of the *Sahiya*:

Selection: A local non-governmental organization had identified the woman and since the NGO claimed that there were no educated women, the *dai* (TBA) of the village was selected as the *Sahiya*. There was no Gram Sabha (Local self-government institution at the village or small town level in India) meeting to discuss the selection of the *Sahiya* and the villagers were not involved in the selection of the *Sahiya*, nor were any serious attempts made to determine if any of the village women were educated.

Training: The *Sahiya* has received three rounds of training since she was selected in 2007, during which the her responsibilities were explained, which included bringing pregnant women to institutions for delivery, making home visits to the women, organizing meetings and discussions in the village and helping the ANM with immunizations. However, the *Sahiya* was unaware about the existence of the JSSK and she even could not correctly name the scheme (JSY) which gave her an incentive to take the woman to institutions during delivery.

Clearly the training did not equip her to transmit information about different maternal health schemes being run by the government.

The *Sahiya* shared that she was not happy with the way in which deliveries were conducted in the hospital as the woman is made to lie down on a delivery table and deliver. She however felt that the traditional method that she used to employ was better, as the woman would squat on the floor during delivery. According to the *Sahiya*, this posture made the delivery faster and easier. She also shared that she had assisted with two home births this year and had used a new blade to cut the umbilical cord; however she did not place any sheet under the woman while she delivered on the floor. In spite of her dissatisfaction with the way in which deliveries were conducted in facilities, the *Sahiya* was also of the opinion that deliveries should take place in hospitals, however she could not articulate why she thought this was important.

Roles: After undergoing three rounds of training, the *Sahiya* reported that she has started working on the following issues in the village:

- ✓ Identifying cases of Kala Bukhar (kala-azar or visceral leishmaniasis); take the person to the health centre to get a confirmed diagnosis and to start medication for those identified with the disease
- ✓ Holding meetings and discussions in the village (however the *Sahiya* has confessed that she is not sure about the objective of holding such meetings and what issues should be discussed during such meetings)
- ✓ Taking the initiative to get a hand pump repaired in the village and working to ensure that the village is clean. She accompanies villagers who fall sick to the health centres for treatment
- ✓ Assisting the ANM during her visits to the village and during the VHNDs
- ✓ Accompanying pregnant women to facilities for institutional deliveries and staying with them for the entire duration. She cleans up the woman, disposes off the after-birth and cleans up the area after the delivery. She also motivates the woman to start breast feeding within the first day of birth.

Transportation to hospitals: According to the *Sahiya*, only she is entitled to phone for the Mamta Vahan to come and in case she is not present in the village, then this task is done by the Anganwadi helper. She held that the Mamta Vahan would not come to the village, if anyone other than herself or the Anganwadi helper made the call. Another *Sahiya* said that anyone in the village could call for the Mamta Vahan, but they needed to inform the call centre that the *Sahiya* was not present in the village. None of the villagers had the toll-free number to call the Mamta Vahan, and neither was this information displayed/wall painted anywhere in the village. Further, even the villagers were of the opinion that calling for the Mamta Vahan was the task of the *Sahiya*. This at times leads to delays and loss of precious time, as the family members of the pregnant woman have to first contact the *Sahiya,* who will then visit the house of the woman (which may be situated in another hamlet), assess the situation, and then make the call to the call centre.

Organizing VHNDs: In her village on the second Saturday of each month the VHND is organized in the Anganwadi Centre. According to the *Sahiya,* she has a list of all pregnant women and children, and she motivates them to come to the VHND for vaccination; however, she admitted that no ANC check-ups (blood, urine, weight, abdominal or blood pressure) is done during the VHND. Another problem is that the VHND is organized on a Saturday, which is the day the Haat (weekly market) of the village is organized and therefore it is very difficult to get all the pregnant women and children to attend the VHND instead of visiting the Haat.

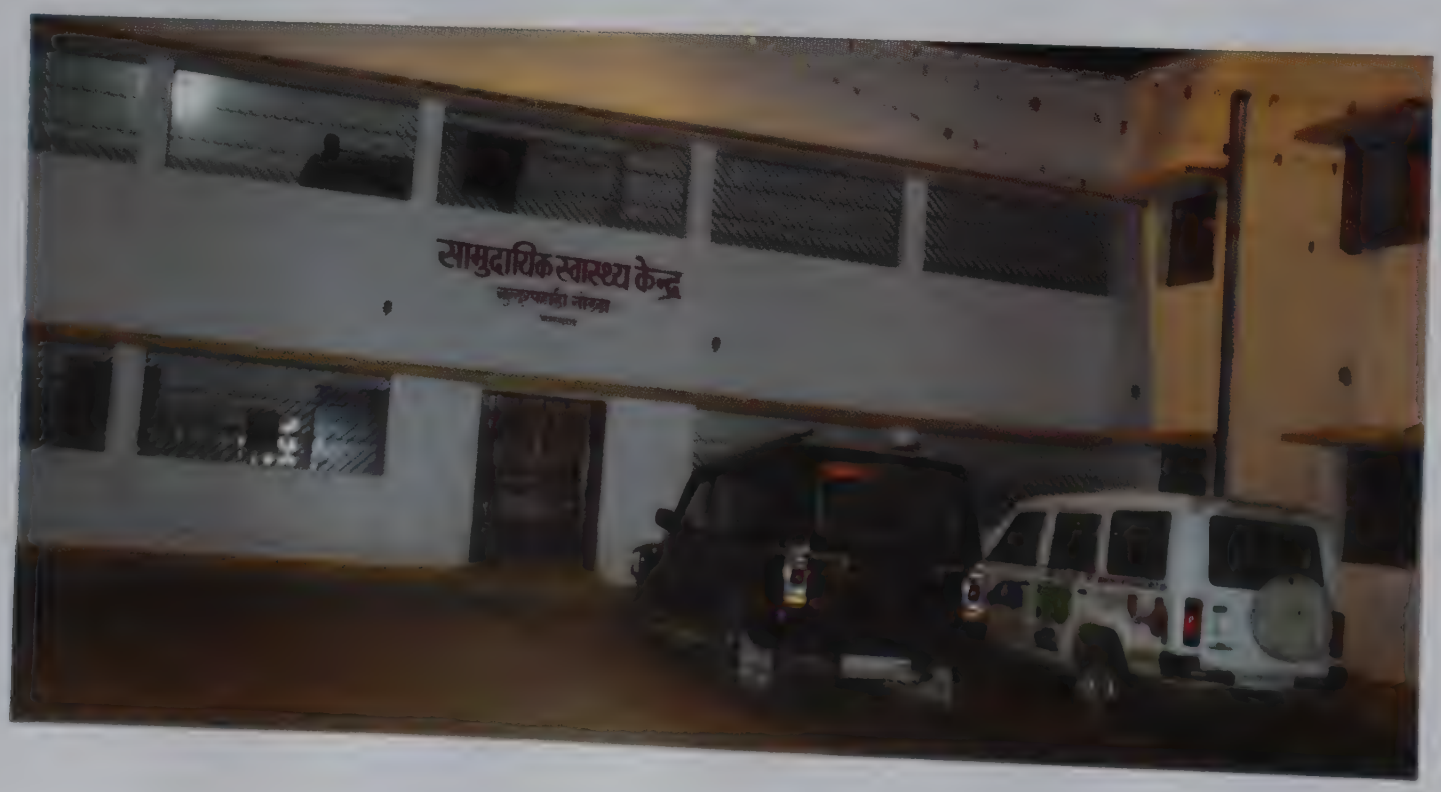
Use of the Untied Funds: According to the *Sahiya*, no committee such as the village health, sanitation and nutrition committees (VHSNC) has been formed in the village. According to the *Sahiya*, the untied fund is credited to a joint account held by the village Pradhan and her. She shared that the Medical Officer in Charge (MOIC) had orally explained to her the items for which the untied fund could be spent and so it was spent on cleaning the village, installing a hand pump, transporting women to the hospital, etc. However she acknowledged that there was no discussion in the village before these decisions were taken.

ii. Facility level Services

The team visited and conducted interviews at three facilities, including the Sundarpahari CHC, the District Hospital Godda, and the FRU at Mahagama.

Sunderpahari CHC: This is located in a very new CHC building (inaugurated on 31 October, 2011). There was also an old CHC building. The new building has two floors (according to the new building plan under NHRM) with many wards and over 44 rooms. The team visited the Female Ward where six women who had delivered recently were present with the infants and attendants. The MOIC informed the team that around 50 deliveries take place each month.

In Sunderpahari CHC there are four positions for doctors, and all four are currently filled. Two are general physicians, but the MOIC, Dr. Alankar Oraon, and another doctor, Dr. Dilip Thakur, are specially trained as anaesthetists. There is one female doctor, Dr. Cecilie Prabha Hembrom, who is undergoing EmOC training and is also trained as SBA. The equipment needed for the Operating Theatre (OT) and Caesarean sections is not yet available, but he hopes that it will be installed by the time Dr. Cecilie Prabha returns from training.



Initially, Dr. Oraon was not very sure about EmOC services and preparedness, but when asked about the stock of magnesium sulphate injections and others, he indicated that there is sufficient stock of magnesium sulphate and other life saving drugs. All 17 ANMs trained in SBA use them, and had been instructed on how to use them. There is no facility for blood storage and there is no plan to arrange for it; however, blood can be arranged from district headquarters if needed.

Under this CHC, which is not recognised as an FRU, there is one Primary Health Centre (PHC) and 15 Health Sub Centres (HSCs), with a total of 44 ANMs deployed. Each of the 15 HSCs has two ANMs. There are 7 Mamta Vahans under this CHC, located at different Panchayats.

The District Collector had initiated some tribal welfare schemes, with which the health department was also trying to engage. For example, the Godda Civil Surgeon (CS) said, *"to support tribal families to accompany the woman for a hospital delivery, we have constructed a 'Basa' (accommodation) facility in the CHC where families can stay and cook during hospitalization of their family members."*

There was also some effort being made to improve services and increase monitoring of the health of pregnant women so as to detect complications in time. Dr. Oraon, MOIC of CHC Sunderpahari, stated that there are some changes in ANC pattern based on the felt gaps. Instead of three ANC checkups, four ANC checkups are now mandatory, with more ANC services such as BP checks, urine tests for protein, and blood tests for haemoglobin being done. This was also mentioned by the CS, Dr. Ram. Further, *Sahiyas* have regular meetings at the CHC on Wednesdays, when they are given information and medicines such as filariasis medicine for distribution. The United Nations International Children's Emergency Fund (UNICEF) district officer said that to improve the system, the monthly monitoring meetings are ongoing, there were few buildings of the HSC, and all HSCs have 2 ANMs. The District CS, Dr Ram, indicated that in order to improve ANC and other services, there are monthly monitoring meetings at the HSC on the last Monday of the month with all *Sahiyas* and ANMs for sharing details of all MCH data under Mother And Child Tracking System (MCTS).

Regarding ***Maternal Death Review***:With regard to the high number of maternal deaths in Sunderpahari block and the importance of Maternal Death Reviews (MDRs), the MOIC of CHC Sunderpahari admitted that due to a shortage of human resources, they are not immediately able to carry out MDRs; however, when they come to know of any maternal death, they first ask the ANM to do an inquiry and after confirmation, the doctors' team does the verbal autopsy and sends the MDR report to the district. So far, no concrete actions have been taken to mitigate the underlying causes, but the MDR reports are discussed at district meetings.

District Hospital Godda: was earlier a Sub-divisional hospital which has now become a district hospital. It has only 46 beds at present, but is supposed to be upgraded to a 100-bed hospital within a very short time. A new two-storey building is under construction

without windowpanes or shutters, and may be handed over soon. This new building is already equipped with new beds and other equipment.

The old hospital has the office of the CS and other offices, a general male and female ward, ANC room, 2-3 rooms (stock and store) and one big hall with 6 beds without sheets for patients and attendants waiting in the back. There is an old small Reproductive and Child Health (RCH) ward, maternity ward with 10 beds in the room, 3 additional beds on the verandah (which has grills), and a new room with a warmer and two cribs. Next to this is situated a labour room with two delivery tables, a temporary wash basin, plastic sheets and partition screens, a few posters on critical-case management, a storage corner with supplies, etc. There were mothers lying outside on a concrete platform in open space who had just delivered a few hours before and were waiting to be discharged. There were about 18-20 expecting/already delivered mothers in the verandah and hall of the maternity ward.

According to the CS of the Godda District Hospital, in other areas like Meherawan, Mahagama, Godda, where there is good coordination between ANM and the *Sahiyas*, the access to maternal health services is quite high, immunization rates have increased, MMR has become quite low (277), and institutional delivery has increased to 20%. At the district hospital, which previously had 120-140 deliveries a month, the current case-load of deliveries has increased to 435 per month, so they are always overcrowded and many pregnant women do not get beds.

CS said now the cases of malaria and kalazar have decreased.A UNICEF official present in the district hospital at that time stated that now there is restructuring and rescheduling for the vehicles as well as training, so now it is able to meet peoples' need, yet due to inaccessible roads, it is still a big challenge to cater to all the women who need it.

Mahagama CHC (FRU): This hospital is managed by Dr. Tarun Kr. Mishra, MOIC, since 2007. He had streamlined many health services and also started doing C-sections in critical cases. Due to his able leadership, this 30 bed CHC had become the ideal health facility of the district, where they provided prompt and appropriate health services and had improved MCH services. When this team visited the CHC, Dr Mishra was on leave.

It was a well organized CHC, where building space was utilized optimally. Near the entrance of the hospital, the old CHC building was made into a general purpose store. In front of the present CHC building on the ground, the hospital had made cement benches with fiberglass covers that served as a waiting area for patients. At the entrance of the hospital, in the

corridor, there were a few cots where general in-patients were treated. Then in female wards as well as maternity ward and corridors, all beds were occupied by pregnant women coming from Mahagama and 4 adjacent blocks. In the maternity ward and labour room there were three labour tables, one waiting table, and two cribs.

In Mahagama the team found that 20 women had already received antenatal checkups on that day. There are 16 Mamta Vahan on rent. The data clerk said that the average number of monthly deliveries of this CHC was over 700 (September 772 deliveries and October 753). Under this CHC there are 29 HSCs and 1 PHC, and every facility conducts deliveries. According to records, in October there were 167 deliveries in PHC and SHCs. The population of this block is 199,800 and there are 29 Panchayats and 21 HSCs. There are a total of 8 doctors, 7 staff nurses and 26 ANMs in the entire block.

Two days a week, sterilisation operation services are provided by two doctors' teams. The day the team visited (22 November, 2013) was a day when sterilization operation services were being provided. The average monthly out-patient load is 2,500, but the staff acknowledged that they do not get enough medicines to be distributed free of charge, so they have to write prescriptions for people to buy medicines from outside. There was a Newborn Sick Unit (NBSU) with four beds. There is a Rogi Kalyan Samiti (RKS meaning Patient Welfare Committee) and the meetings were quite regular in recent months, where they have taken some decisions for purchases. There is no blood storage in the CHC and hence in cases of maternal complications in which blood transfusion is needed, they are forced to refer such cases. But ante-partum haemorrhage (APH) and other critical cases are dealt with here.

The two female doctors and the staff nurses in the Mahagama FRU maternity ward said that most of the women come for childbirth having received no proper ANC: many are anaemic (severe to moderate) or have other high risk signs that are not mentioned, so they find it difficult to treat serious cases where blood transfusion is needed. They refer those cases but they do manage pre-eclampsia, APH and other critical cases by giving magnesium sulfate injections and C-sections if needed.

The team was told that between April and November 2013 (with a gap of a month), there were 66 C-section cases done very successfully at this facility. This is remarkable because the staff are not trained in EmOC, but they have been doing surgery, particularly C-sections, for a long time. Recently, the State Health Society issued an order that only those formally trained in EmOC can perform C-sections. Consequently, for over a month, the C-section operations were stopped and people found it very difficult. Finally the DC of Godda reversed the order and permitted doctors to conduct C-sections for the welfare of the public, so once again C-section operations are taking place.

Section C - Challenges identified

Almost every health department official interviewed did express that they were aware of the special issues of tribal communities. These included some language, literacy and cultural

preference issues. In addition, they identified many issues of the health system service provision in Godda.

i. Language, literacy and cultural preferences –

The District Hospital officials felt illiteracy is a big hindrance for communicating to the tribal communities the benefits of the health system. In Sunderpahari CHC, the MOIC doctor indicated that 50-60 percent of the frontline workers are Santhals, so they are able to communicate to their own community. However at present there are no Pahariya ANMs in his CHC, so language and communication is also a problem with Pahariya patients.

The District CS acknowledged that there is a big gap regarding the acceptance of modern allopathic medicinal systems by the tribal communities (as they rely more on their tribal medicinal system); as a result, they do not access the government health services until the last moment when the situation is beyond their control.

The CS suggested that the Health Plan should match with the felt needs of tribal groups and be more flexible; for instance, there can be Ayurveda, Yoga, Unani, Siddha and Homeopathy (AYUSH) or indigenous treatment offered as well as allopathic system so that tribal communities can have faith and trust the hospitals. The many good health practices of tribal communities should be incorporated in health trainings and practice, so that they can relate and find it acceptable. The Sunderpahari MOIC also said that we need more flexibility and understanding of tribal culture, and more acceptances of their age-old good practices rather than forcing them to accept medical practices to which they cannot relate.

II. Service provision –

✓ **Outreach** - MOIC Sunderpahari said that the block has 220 Revenue Villages and 122 AWCs, but they have only 103 places of outreach services for VHND. Thus there is lack of human resources to cover all villages and hamlets. In particular there are 125 Pahariya villages in the most inaccessible mountain tops, which are not covered by outreach services. He admitted that due to inaccessibility, lack of good roads and communications networks, many ANMs or *Sahiyas* may not reach many hamlets, so there are underserved areas for even critical areas like child immunization. Dr. Ram admitted that there is a gap due to no incentives for remote and inaccessible areas. They are trying to bridge the gap from tribal welfare schemes under the initiative of the DC.

He pointed out with only 196 *Sahiyas* are in position as compared to the need for 214 *Sahiyas* in Godda block. Most of them were selected by Non-Governmental Organizations (NGOs) and some of them initially joined thinking it a government job, so many of them now are not motivated to work as the first health-service contact for villagers. Some are quite callous in denying women the expected services, but due to state directions, such *Sahiyas* cannot be replaced by decisions taken at the block or district level.

Likewise, according to the MOIC of Sunderpahari, some Village Health and Sanitation Committee (VHSC) were also formed in 2007 by NGOs where many unsuitable persons became members who were only interested in the money of the United Fund. According to officials in the district hospital, restructuring is now taking place, the VHSC has now become the *Sahiya* mentoring groups. Government officials are involved in the formation of such committees, and 31 committees are in place today.

When the team asked the Godda CS about the burning health issues of Godda, as in past there were reports of maternal deaths from Sunderpahari and Poreyahat blocks, the CS said that there is staff shortage (31 posts are vacant) and more facilities are required in such a remote tribal belt; yet with the help of the *Sahiyas*, they are covering outreach. He also agreed there is a great lack in ANC, particularly in Sundarpahari, Boarijor and parts of Poreyahat.

✓ **Referral** –The MOIC of Sundarpahari said that normal deliveries do take place in his hospital, but critical cases are referred to the District Hospital as, per referral protocol, they have to refer to a higher facility. The team asked the MOIC whether management of critical cases of complicated deliveries can be done immediately at District Hospital with APH management, uterine rupture management, C-section and blood transfusion. MOIC was not sure about such quick arrangements and response. He said that at District Hospital, blood storage is available, along with facilities for C-section and critical case management.

However, when categorically asked what he would do if his family member needed a referral, he replied that he would send them either to Bhagalpur Medical College Hospital (in the neighbouring state of Bihar) or any good private clinic, considering that better quality services would be available there. The MOIC of Sundarpahadi said that he cannot refer officially any case to Bhagalpur Medical College Hospital (MCH) as he cannot send the vehicle out of Jharkhand state; so people have to take their patients in a private vehicle across the border to Bhagalpur MCH. However Dr. Ram (CS) said that there is no difficulty in sending such cases from PHC to CHC to FRU or Bhagalpur Medical College Hospital. The Mamta Vahan may not go, but under JSSK they could refer such cases in their own vehicle.

Although Godda district organizes voluntary Blood Donation Camps regularly (25-30 each year) where even the DC of Godda donated blood in 2 camps, yet they do not have a guaranteed supply of blood. The Godda District Hospital does not immediately get blood whenever required, as their Mother Blood-bank is in Deogarh (2 hours journey, 65-70 km away). Thus, a journey of at least four to five hours is required to fetch blood, so it may actually be quicker to send the woman to Bhagalpur Medical College Hospital for life-saving services.

The MOIC of the CHC at, Sunderpahadi admitted that when they refer out patients they write an Outpatient Department (OPD) slip giving all details about the patient's treatment; however they have never thought of ringing up the District Hospital to give advance notice about referred cases. He admitted that complicated or critical cases are referred to Godda as they have blood storage, but some cases are beyond their control, and hence about 10 cases per month are referred to Bhagalpur Medical College Hospital (Bihar).

✓ **Staffing** – The CS noted the challenges of providing leadership; there are frequent transfers of the administrative posts, so before they are able to implement positive changes, those positions are changed. When one motivated doctor can provide continuous leadership, as in Mahagama FRU (CHC), the functioning is far better than this District Hospital: 100% institutional deliveries are taking place and they are also managing all services very efficiently with limited resources and means. This is the result of the able administration of the MOIC of this FRU.

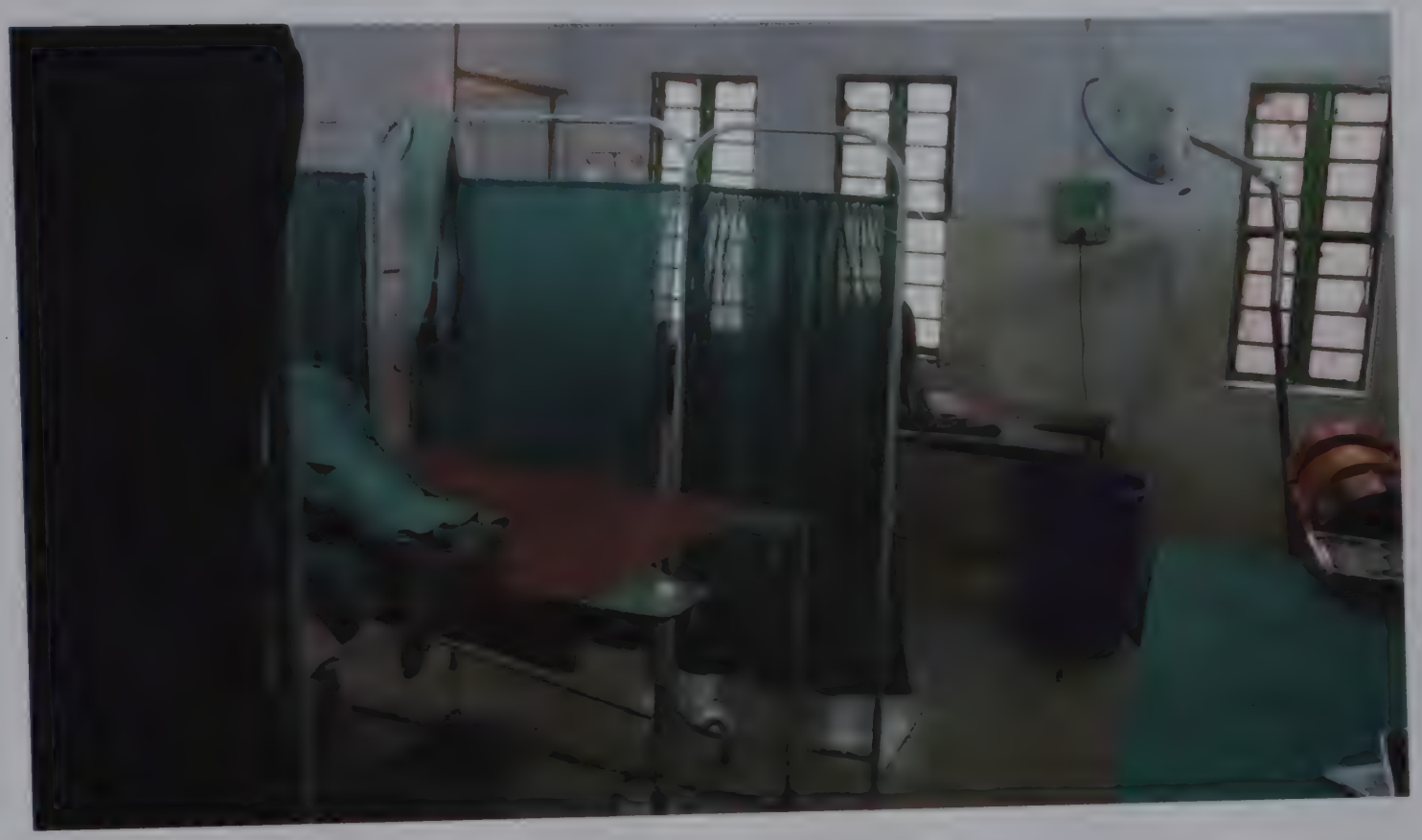
MOIC Sunderpahari said there is no incentive for any service providers to serve the inaccessible areas, so many of the older health department staff are not motivated to serve such areas. There is a need for better communication and commuting facilities and good all weather roads, incentives for staff to work in inaccessible and different remote areas. Personally he has been posted here over two years and has stayed on, and is trying to motivate other staff members.

He said the doctor who had SBA training did not feel confident about using her skills, but he hopes that after her EmOC training she will feel confident to conduct C-sections. The OT and other basic arrangements will be ready within a short time in the CHC. The MOIC and other staff said that there is an urgent requirement for sufficient trained, skilled, dedicated young local Frontline Worker (FLW) and other staff to see that all areas and hamlets are served. New programmes are added every day, such as the School Health Programme, Adolescent Girls' health programme and so on.

In the Godda District Hospital, the situation was worse regarding the infrastructure, facilities and staff compared to an average District Hospital (DH). There are sanctioned posts of nine Medical Officers but they have only five regular doctors with an additional six doctors on deputation. There are three women doctors (of whom two have received EmOC training). However, in the Citizen's Charter on the hospital wall, it was written there will be 10 male doctors, 4 female doctors, 2 Bachelor of Dental Surgery (BDS) Dentists, and 23 nurses available. In the District Hospital, the team found the maternity ward overcrowded, and could clearly see the problems of the staff in managing patients; providing accommodation, supplies and medicines; and doing all paperwork with meagre human resources.

✓ **Facilities** – At the Sundarpahari CHC, some equipment and instruments are needed, and upgrading the facilities to provide quality services. The MOIC also felt that better training methods were needed for all levels of health personnel. He identified the need for building public confidence and better convergence with other departments, so that other development issues are addressed, such as roads, water supply and sanitation, education, and so on.

In Mahagama, the staff acknowledged they do not get enough medicines to be distributed free of charge, so they have to write prescriptions for patients to buy medicines from outside.



✓ **Antenatal records**: Expectant mothers do bring their ANC cards to Mahagama for delivery, but the FF team found that these cards are not properly filled out to provide all needed information or high risk identification. This was brought to the notice of the staff, and the nurses also admitted that ANC cards do not give a clear picture of the health condition of the expectant mother. Postpartum Haemorrhage (PPH) and Anemia are common critical conditions they handle during C-sections, but cases with heart and other problems with acute anemia are referred out as the blood storage facilities and ICU are not up to the standard, so sometimes they ask them to take the patient to Bhagalpur Medical College.

When the team interacted with Dr. Puja and Dr. Vandevi Sahay, both said that it is a very big challenge for them to manage critical cases with no proper ANC records in high risk conditions. Both the female doctors felt that poor ANC and not identifying and appraising families of all danger signs are leading reasons for maternal death without proper and timely services. Though they try their level best to manage APH and other critical situations with inadequate staff, some cases are beyond their capabilities and they have to refer. They also liked the idea of mobile communication of referral cases with complete background notes, so that time in both diagnosis and in treatment could be saved.

Section D - Plans of health department for improvement

When the team met the Health Minister Mr. Rajendra Prasad Singh, who had recently taken charge, he said as a first step he had to take disciplinary action against at least six Civil Surgeons and dismiss 133 doctors who were found to be almost always absent in their posting facilities. He also tried to regulate the system by approving the pending appointment of 201 doctors. He is opposed to giving very meagre amounts as salaries for contractual doctors (Rs.20,000 each month) which does not attract doctors for rural service provision. Being also the Finance Minister, he has proposed a revision in the honorarium of doctors and para-medical staff, and incentives for *Sahiya*.

The Health Minister said he was eager to take action to improve the health system. He said that there is a dearth of institutions for training of ANMs and other paramedics, so he has also sanctioned two Nursing Training Institutes. Being in charge of several key ministries, he could take these steps.

The Health Minister stated that he was strengthening the ambulance services so that villagers could access hospitals. The Health Minister also said that since the *Sahiyas* are the critical key link person between the community and health facility, he has already given cycles for their enhanced mobility and connectivity and ordered backlog payments of *Sahiyas* to be released. The Godda district UNICEF officer said the Health Minister is also clearing the way to sanctioning mopeds for ANMs.

The Godda district Civil Surgeon acknowledged that services need better outreach to the doorsteps so that tribal families did not feel alienated. In addition, the local transport issues for remote villages could be addressed by having a '*doli*' or 'stretcher' service that could bring the patients down to the Mamta Vahan or ambulance waiting on the motorable road. Dr. Ram said that the district monitoring system of the VHSCs is being made efficient and strong. He agreed that Panchayat and other tribal leaders could be utilized as motivators to increase the community's use of the health system. Moreover, if the training of local frontline workers could be done using some locally adapted modules incorporating the good practices of tribal communities, that would certainly help to improve the situation.

IV. Discussion

This report provides a small snapshot of the situation in Godda district, with reference to mainly Sundarpahari block and the backward tribal communities. Despite its obvious limitations, it indicates some of the general trends in the area, which has shown a worryingly high number of maternal deaths independently reported. It emerges that the women of these tribal villages have not been able to access basic health services such as ANC or immunization for their children in the case of PVTG communities. As a result, they are totally cut off from health facilities and all of them have opted for child birth at home, not seeking care even during complications.

We may also examine the findings of this report on the basis of the human rights framework which calls for maternal health services to be available, accessible, acceptable and of high quality.

A. Are services available?

Regarding the availability of services (providers and commodities) in health facilities, it is a mixed picture. Clearly the government has tried to put in place the required human resources in health facilities (for example, anesthesia training for the Medical Officers of the CHC), yet there is a significant shortfall. While the FRU is well staffed, and even offers C-sections, it is not accessible for the women of the Sundarpahari area. Their trajectory in case of complication is to reach the local CHC and onwards to the over-crowded District Hospital from where they are sent on across the border to Bhagalpur.

An additional factor is the availability of medicines: for an FRU with an extremely high case load (around 700 deliveries in a month), it is strange that their medicine stocks run out, compelling them to prescribe medicines from the market.

Regarding services at the community level, the situation is fairly grim. The ANMs are not reaching the villages, the health sub-centres are not easily accessible for many hamlets in the village, and the VHND is not taking place in even half of the villages (103 VHNDs across 220 Revenue Villages). As a result the ANC provided is very inadequate; it is restricted to TT injections, but no screening through Hb tests, BP measurement or any other examination. Family planning services are not available for the PVTGs owing to a government approach that believes in "preventing them from dying out" by refusing contraceptives, which leads to frequent pregnancies.

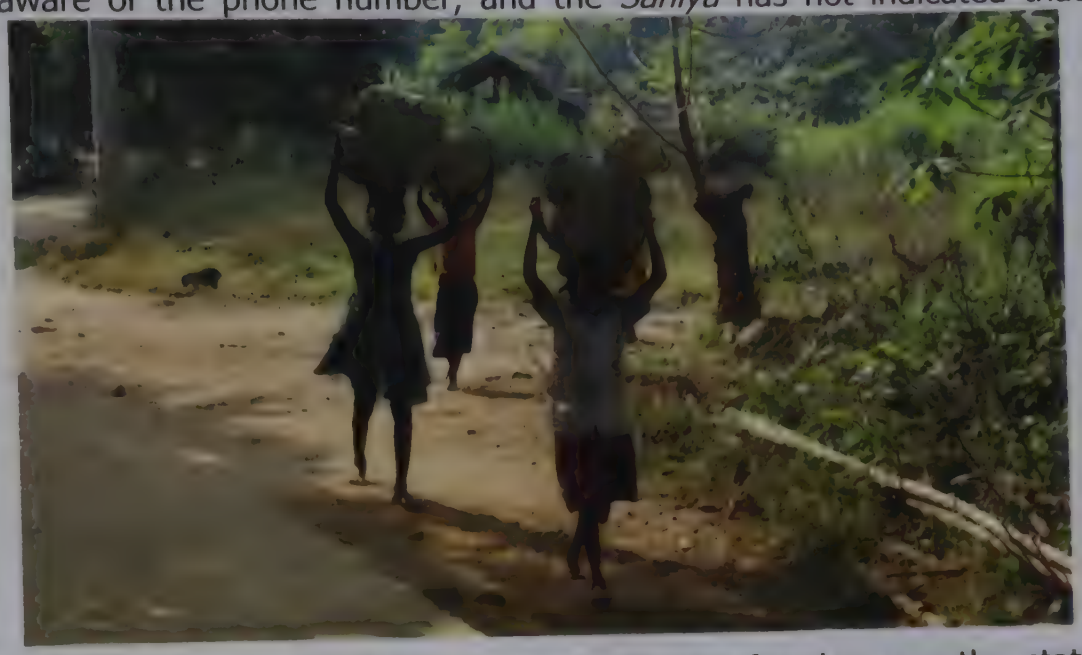
There was not enough interactions with the *Sahiyas*, but from the villagers' reports, their services too are not reaching many hamlets owing to distance, caste barriers and other reasons of motivation. The local health manager has indicated some barriers with changing *Sahiyas* or getting new ones selected, owing to objections from state headquarters. There are evident challenges with training *Sahiyas* in a region where literacy is so low, since educated women will not be available to volunteer; however, special methods for training low-literacy groups do not appear to have been used. Consequently, the capacity of the *Sahiya* appears inadequate for her roles.

One of the results of the lack of community outreach is that people take recourse to the local informal practitioners, including the *Dom,* the *Ojha* and the RMP. We are not aware of the quality of care provided by the TBA, who usually gets a few hundred rupees and a *sari* along with some grains; however, one woman reports paying Rs 2000 after a complicated labour. The RMP likewise provides multiple injections of an unknown variety during labour (possibly oxytocin), and has not received any formal training to handle complicated births. It was reported that RMPs are also called in for malaria cases, but they are expensive, therefore women do not receive their treatment. The herbalist on the other hand appears to have managed malaria cases quite successfully, including malaria in pregnant women.

B. Are services accessible?

As described above, roads that can be used throughout the year do not connect the villages of the primitive tribal groups. Many tribes also live in remote villages on the top of the hills, only reachable by footpaths. The villages are surrounded by forests, and some are reached by crossing rivers without bridges, which is impossible if it rains. The team visited three such villages, where it took some time but was certainly not impossible to reach the community. However, health providers do need some incentives to make this extra effort. This was mentioned by health managers at both the block and the district level.

In terms of local transportation, most villages are so small and the people so poor that there is no vehicle in the entire community. They are reluctant to approach another village for help with transport. The government has made a massive effort with the Mamta Vahan system, and there are adequate numbers of vehicles being used as ambulances. However, the villagers are not aware of the phone number, and the *Sahiya* has not indicated that anyone can call for the ambulance. Owing to the hilly terrain there are also issues with connecting cell phones, and the lack of electrification makes cell phone charging difficult. There is also the need for *Dolis* to transfer women from the remote villages to the road-head. Another issue is of referral across the state borders, since most doctors prefer to send complicated cases to Bihar Medical Collage (BMC) and the Mamta Vahan refuses to do so. There is need to address this problem.



The only services accessible as mentioned above are the *Dom*, the *Ojha* and the RMP. In fact, where the PHC is dysfunctional, there are a number of flourishing RMPs at the street corner of the Additional PHC in the block. The population calculations for health staff make it difficult for proper coverage, since the communities live in small scattered hamlets in far-flung villages; and this is a persistent challenge in an area with scarce human resources.

C. Are services acceptable?

In the three villages visited, all of the women had given birth at home, even though some had had complications and near misses. There was also a maternal death in one of the villages. Yet the women did not consider going to the local health facilities. The *Sahiya* herself was not convinced about the style of childbirth promoted in the institutions. The CS mentioned that special efforts had been made, for example the construction of '*basa*' where tribal women and their families could stay, but this facility was not mentioned by the medical officer, which raises the question as to whether these are still in functioning condition.

There are language barriers in addition, for the Pahariya tribes speak a different language and there were no nurses of that community posted in the facility. The tribal communities are seen as ignorant and uneducated, and their practices are looked down upon. The health system has made no effort to integrate the tribal health system and integrate some of the good practices so that the tribal feel less reluctant to use the health facilities. As it stands

now, they avoid using government health facilities until matters have gone too far, and then it is usually too late. The healing herbs of the tribal communities (also called ethno-medicine) have neither been documented nor studied and therefore are not incorporated into the health system. The Godda CS did mention that this should be done, but somehow he has not been able to take this up on his own.

The maternal deaths and the near-miss have impressed upon the communities that their local *Dom* or *Dagri buri* (TBA) is not adequately trained; however, the health system has completely ignored these providers and they are not integrated into the services. It is interesting to note that when the *Sahiya* (who was a TBA) brings a woman to the hospital, she is expected to clean up the afterbirth, which was the regular role of a TBA in home delivery.

D. Are they of high quality?

We do not have evidence of the quality of care in the health facilities as no one that we met had used the facility for childbirth. There appeared to be a general reluctance in the community to consider this option. However, we do know that the DH was overcrowded and women were asked to lie in the verandah or in the open courtyard with newborn babies. The FRU appeared to be providing better quality EmOC to the women and consequently had a high caseload. However, it caters to the more advanced Santhal community, and the Pahariyas mostly are left out.

The Sundarpahari CHC is unable to provide skilled attendance in case Emergency Obstetric care is needed, since the trained doctor has not yet begun carrying out C-sections. The DH is unable to carry out blood transfusions although it has blood storage (owing to "unreliability" of stock); and strangely enough, there is no functioning blood storage at the FRU in Mahagama. For a region where everyone admits that women have very high anaemia, this is untenable.

We also know that antenatal services are unable to detect high-risk signs since, according to available data, less than a third of all women were tested for high blood pressure and hardly one-fifth for haemoglobin (AHS 2011). The secondary data indicates that post-natal care is also low, and the women we met in the villages had never received any such antenatal or post-natal care. Banerjee's documentation indicates that this is responsible for lives lost, since anaemia and pre-eclampsia were not detected in time.

In terms of attitudes of the providers, we feel that tribal health providers may be marginally better, but that there are also issues among sub-tribes that need to be addressed. The CS appeared to be thinking about the problems faced by tribal communities, but it is not known whether this translates into staff behaviour with the women. The DC also appeared to be making some effort to address the special concerns of the tribal communities, but we could not gauge how far this was effective.

It is clear that the private sector is completely unregulated. They have made steady inroads into the area, providing care to women in case of emergency and also treating various forms of malaria, including cerebral malaria, without any formal training.

Regarding services for nutrition, the AWC appears to provide THR sporadically, and information does not reach all the women. In the more remote villages there are no AWC, therefore the THR does not reach. It is true that the PDS is regularly functioning, and although it is far, people do take the trouble to access it. But it does not incorporate the local grains that are richer in nutrients, and instead provides the standard cereals that are given all over the country.

Regarding the mechanism of the VHND, which is seen as the solution to all service-provision problems, the Sundarpahari MOIC himself admitted that with 220 Revenue Villages (divided into many more hamlets), he is able to organize only 103 VHNDs. Clearly, service outreach is a major issue in this area.

V. Conclusions and Recommendations

NAMHHR carried out this Fact-finding mission after a paper was published in Economic and Political Weekly (*Stairway to Death: Maternal Mortality Beyond Numbers*, Banerjee et al, Aug 3, Vol XLVIII No. 31, 2013) that examined 23 maternal deaths occurring in one year among young, poor women mostly from tribal communities (including PVTG) in two blocks of Godda District (Jharkhand). The objective was to develop an understanding of the situation of maternal health and related determinants such as nutrition, to explore issues of service provisioning, and to suggest alternate strategies to improve health and nutrition services in the area.

The secondary data already indicates that the "one-size fits all" template approach to maternal health will not work in this area: in Godda district, childbirth at home is 75.2 percent, three times the rate of institutional delivery (24.4%). Yet the government has ignored the safety of these women, and put their lives in jeopardy by not putting a plan in place for safe home births with effective referral linkages in case of complications.

Moreover, within the Sundarpahari Block with 79% tribal population, there is a high proportion of primitive tribes like the Pahariyas, and the situation is exacerbated by low literacy (27%) and poor communications. There is poor convergence between departments towards saving the lives of the women of these PVTGs, leading to avoidable maternal deaths. Their traditional food patterns linked to the forests and the robust practice of mixed organic farming has been disturbed by the introduction of PDS grains and the reluctance of the forest and agriculture departments. Iron-rich foods growing in the area have been

ignored and women have been asked to take tablets during pregnancy, which is alien to tribal culture.

Their local knowledge of herbal medicines and traditional birthing practices has been ignored and eroded by the intrusion of an exclusively allopathic health system that wants them to come to hospitals where no one speaks their language. Most of them have not been through school, and wide communication gaps persist. While roads lead up to the new factory being set up by a large industrial group, there are no roads for the villages of the PVTGs, who prefer to live amidst the forests and hills.

Different tribal areas and their health problems need to be seriously studied, both within Jharkhand and in other areas of tribal communities. The PVTGs require anthropological studies to understand the underlying reasons: what are acceptable health practices for different tribal groups from the government system, and what good health practices exist within their own tribal health systems, which they would like to retain. In addition there should be investigation into their nutritional status, as well as study of local food and agriculture practices.

Given the geographical situation of Godda district, it is difficult for health services to reach communities located deep in the forests. As a result, we observed tribal villages where women have never received antenatal care, have no information about JSY or JSSK, and have all had home births with some near misses and maternal deaths; in PVTG villages the ANM has never come, and none of the children were immunized.

The original objectives of the Fact-Finding Mission to Godda District, Jharkhand were:

- To develop a greater understanding of the condition of maternal health in tribal areas of Godda district by exploring health services and related determinants such as nutrition.
- To explore alternative strategies that would be effective for maternal and child health and nutrition in tribal areas.
- To seek answers to questions relating to service provisioning of the responsible line-departments - including the provisions that exist to tackle severe anaemia among tribal women and girls.

Following the researchers' observations from two days of interaction with the local frontline workers, villagers and facility visits, the following are our recommendations:

A. Inter-departmental convergence
B. Improving health facilities in tribal areas
C. Re-orientation of community and facility health providers
D. Integration of healthcare with nutrition services
E. Community monitoring and accountability by strengthening the capacity of members of Village Health, Sanitation and Nutritional Committees

A. Inter-departmental convergence

A massive exercise in convergence is needed to ensure that the ICDS system, the Rural Development department, the Forest department, Education department, Agriculture departments, etc. are made aware of the special issues of the area, especially the situation of the PVTGs, and that synergistic efforts are put in place. For example, roads are needed, bridges have to be built, communications strengthened in the interior villages through alternative means, and schooling, water and sanitation improved.

In such a challenging situation, the best results can be obtained if the government departmental staff working on forestry, agriculture, women and child development, tribal affairs, rural development and health work together in a concerted strategy for improving the situation of the PVTGs. In addition, the state health system and civil society should join hands to ensure that health services reach these communities.

B. Improving health facilities in tribal areas

1. Availability, affordability, and accessibility of high quality health care services must be ensured in tribal areas by making special efforts to get adequately trained staff in place. At present some ANMs are unable to even check high BP; doctors with training are unable to perform C-sections. Mobile-phone based methods may be considered to strengthen and support these providers in the peripheral areas.

2. Blood transfusion services which are a critical life-saving component are not being provided anywhere in the district, and must be immediately instituted in the District Hospital and FRUs.

3. There are a number of "shadow areas" which have not been properly mapped by the health department, where no services are reaching (even immunization and antenatal coverage). Staff to population ratio has to be done differently (especially for remote and difficult terrains); facilities and services should be enhanced to cover the entire tribal population. Revised pay structure with additional incentives should be considered for staff working in the tribal area, with better residential facilities and health infrastructure.

4. The attitude of health service providers is not sensitive to tribal culture or practices, and this deters the local people from availing health services. Language issues are a major problem for tribal groups accessing health care. This should be addressed in Information, Education and Communication (IEC) materials and innovative communications used in tribal areas (village plays; pictorial materials, etc.). All institutions should have a Help Desk 24x7, staffed with sensitive and concerned persons knowing local dialects and local customs and traditions as well as being able to facilitate pregnant mothers in health facilities.

5. There should be a special effort to engage PVTG nurses and health personnel who speak the local languages, by providing them with scholarships and other affirmative action. At present even literacy among the PVTG communities is very low, therefore additional effort is needed by the Education department to strengthen schools and enrolment.

6. Addressing the lack of information: The tribal community living in remote areas often has no knowledge about health schemes, the role of the ANM, ASHA, AWW and so on, and therefore cannot effectively claim their entitlements. They are also unaware of entitlements through the MNREGA. Therefore special emphasis should be placed on ensuring that such

information reaches the people through using various IEC materials. Wall paintings, displays, posters, and other IEC materials giving the toll free number of the vehicle for emergency transport/maternal transportation (and the fact that anybody can make the call) should be disseminated widely, so that people in villages have this information. Street plays and community radio (using narrow-casting) can also be used in remote villages to make communities aware of their entitlements and how women's lives can be saved.

7. Integration of the traditional systems with allopathy at each level: To integrate/imbibe the tribal system of treatment along with modern allopathic system for better acceptance by the tribal community of the services offered. We need to acknowledge that tribal communities have a different culture and often the government health system does not provide services acceptable to them. The state health care system has not integrated even so-called AYUSH, but it is now time that good health practices of the tribal communities must be integrated. Different tribal areas and their health problems should be studied (within tribal belts of India) while also trying to understand the underlying reasons, and investigate what health services are acceptable for different tribal groups. Tribal health practitioners should be accepted for good treatment they may be providing, and their folk-medicines studied and included where possible. There is a need for identification, rrecognition and capacity-building of community-based Birth Attendants, so that they can conduct safe childbirth at home when needed.

8. Referral protocols must be flexible to make needed services available within timely reach at the appropriate facility. Transport from the village to the road can be facilitated through palanquins or *dolis*. But there is an issue with referral for complications. Phone-calls need to be made to the referred facility, so that they are prepared before the woman arrives and precious time is not lost trying to get the staff ready to provide treatment. Additionally, the ambulance services at present refuse to cross state borders, although life-saving care may be more easily accessible across the border; this has to be changed so that families do not waste precious time trying to arrange for private transport. Additionally, Mamta Wahan has to be made available to get back home after each delivery (or even maternal death).

9. Since even the long-established entitlements of NRHM are not reaching some women, there is need to ensure that benefits of various schemes like JSY, JSSK and Rashtriya Swasthya Bima Yojana (RSBY) ultimately reach beneficiaries and in time.

10. Maternal Death Review in both health facilities and in the community, followed by sharing of key findings and areas for improvement in health system (so that we are not only blaming community/family for maternal deaths). Services should be strengthened and all cases be analysed to improve service facilities. Compensation/Insurance must be paid to the families where a maternal death has occurred, and if a case of denial of care is established, action must be taken. Immediate care to be provided to any surviving children.

11. Adapting service delivery and human resource deployment through a "Hub-and-Spoke model" so that all normal deliveries can take place with SBA (can be a community-based birth attendant) at home or at HSCs. Only critical cases should come to the highest facility, which should be well equipped and well prepared with appropriate training, drugs, and materials.

12. There is also need to examine the question of why PVTG women may not have any access to contraceptives. This is a continued violation of their reproductive rights.

13. Special focus for awareness and screening for tribal-specific diseases like Sickle Cell Disease during pregnancy, malaria, etc., and developing appropriate protocols for managing such cases.

C. Re-orientation of community and facility health providers

1. Training of local women as SBA, who can also be identified from among the community TBAs or women who assist other women during labour and childbirth, so that normal deliveries can be conducted in the village itself. However the identification of danger signs should be taught not only to the birth attendants, but also to the community women so that families become aware of the circumstances under which the pregnant woman should be shifted to a health facility in case of complication. The 108 Emergency Management and Research Institute (EMRI) type of ambulance with trained paramedics should be readily made available for promptly transporting a delivery case with complications to an appropriate functional FRU.

2. More flexible training modules should exist for frontline workers, who should be from the local communities so that outreach will improve (complete and quality Ante-Natal check-up identifying high risk cases, regular analysis of ANC data at block level and discussions with concerned ANMs, at least three post-natal visits).

3. Since the women selected as ASHAs/Sahiyas in the tribal region are mostly not literate, it should be ensured that the training material used is pictorial and all such community volunteers should be trained separately, to enable a richer discussion of issues and build their confidence to articulate the problems they face. Such a training would ensure that they have understood the issues properly, and thus improve their outputs.

4. There is need to make better use of mobile phones and enhance the mobility of ASHA/ *Sahiya* community volunteers and ANMs, such as by offering loans for scooters. ANMs also need proper residential facilities so that they can stay near the HSCs with basic drugs, equipment (depending upon the local situation), solar electricity, along with transport and communication back-up from the PHC or CHC.

5. The poor local coordination between frontline workers needs to be changed, with strong convergence of services of ASHA/AWW and ANM at the village level. The roles and responsibility of each of the workers should be clearly re-defined

6. There is a need to document traditional folk medicinal and midwifery practices in different communities, and come out with more community-friendly and accepted options on MCH.

D. Integration of healthcare with nutrition services

1. The VHND should be organized keeping in mind which is the day of the weekly market (Haat) in the villages. This reduces the attendance of the women and children in the VHND, and therefore the VHND should be rescheduled to another day.

2. In many areas, the VHND has in essence become a vaccination day as other than immunizations, no other ANC services are provided on that day. This day can be used effectively to provide ANC services to women in order to identify complications. The VHND is a good opportunity to provide ANC services to pregnant women, and providing a refresher course/training to the ANM on the five essential ANC checks must be organized.

3. Provision of community-based services for supplementary nutrition – There is a need to study and promote locally available nutritious foods for the Supplementary Nutrition to be given to pregnant and lactating women and adolescent girls. We also need to understand what are the beneficial health practices of their own tribal health systems, which they would like to retain, and their nutritional food and agricultural practices should also be taken into account. Instead of depending on packaged food from other places, the local communities can be encouraged to cook local food using local recipes for the THR.

4. Promotion of local nutritious food crops - Since the locals are already growing millets, pulses and other crops, increased cultivation can be encouraged by offering minimum support prices, and procurement through local Self-Help Groups to be supplied to the PDS (we found the PDS functioning better than the ICDS). The AWW or Village Health, Sanitation and Nutrition Committee (VHSNC) members can be encouraged to grow locally available nutritionally rich vegetables and tubers for self consumption and provisions for ICDS/Midday Meal (MDM) and SABLA scheme (Rajiv Gandhi Scheme for Empowerment of Adolescent Girls), rather than depend on packaged food transported from outside.

5. Schemes like the SABLA and other comprehensive strategies for educating and empowering adolescent girls are essential for these areas, as early marriages and early pregnancies are a major cause of maternal mortality among the tribal communities.

E. Community monitoring and accountability by strengthening the capacity of members of Village Health, Sanitation and Nutritional Committees:

1. Monitoring of the services provided by the ANM in the village and the services provided by different levels of the health system is essential to ensure that there is improvement in the functioning of both.

2. After receiving training, the *Sahiya* should take an active role in raising health awareness in the village, draft the village health plans, and facilitate discussion among the villagers in the Gram Sabha meeting regarding the proper use of untied funds.

3. Addressing the lack of information: The community has no knowledge about health schemes, the role of the ANM, MGNREGA, etc., and therefore cannot effectively claim their entitlements. Special emphasis should be placed on ensuring that such information reaches the people through using various IEC materials.

4. Ensuring accountability: This can occur only when the community is informed about the roles of the providers and the providers accept the necessity and the importance of ensuring that accountability is in place. If service providers are unable to ensure accountability, then a process of dialogue with the community should be established to discuss the problems/obstacles that are hindering the process. If dialogues do not resolve the issue, then it might become necessary to organize a public hearing.

5. Community involvement can be enhanced by provision of community-based services (for supplementary nutrition, promotion of locally available nutrition foods, etc.).

Annex One– Schedule of team and respondents

Full team: Jashodhara Dasgupta, Abhijit Das, Ajay Lal, Devika Biswas and Vasavi Kiro along with Soumik Banerjee and Md. Sarfraz Ali

Date	Site visited	People met	Members of team
20 Nov	Ranchi civil society meeting (Annex Two)	15 members of local CSOs	Full team
	Meeting with Director Health Services and Director in Chief, Health	Dr. Sumant Mishra and Dr. Praveen Chandra	Jashodhara and Dr. Abhijit Das
21 Nov	Ekjut office	Sarfraz and Soumik	Full team
	Hamlet A Tola of Revenue Village X	Community women, local *Dai,* local *Sahiya*	Full team
	Hamlet B2 of Revenue Village Y	Community men, women	Full team
	Community Health Centre of Sunderpahari block	MOIC and team (BPMO, Lab Tech and Accounts person)	Full team
22 Nov	Hamlet C2 of Revenue Village Z	Community women, village Pradhan	Soumik, Ajay, Vasavi and Jashodhara
	Sadar Hospital Godda	Civil Surgeon	Dr. Abhijit Das and Devika
	Mahagama First Referral Unit	Staff nurse and the pharmacist	
23 Nov	Camp Office of Health Minister in Ranchi	Health Minister Shri Rajendra Prasad Singh	Vasavi, Dr. Abhijit Das, Jashodhara, Devika

Health facility	Health official/service provider with whom the team interacted
Sunderpahari CHC	Medical Officer-in-charge, Budget, Planning, and Management Officer (BPMO), Lab technician, Accountant and Pharmacist
District Hospital Godda	Civil Surgeon (CS) Dr. Pravin Ram, Hospital Manager Mr Mukesh, Dr. (Ms) Puja Bhagat in charge of EmOC, Dr. Vandevi Sahay (Gynaecologist on duty and Skilled Birth Attendant (SBA) Trainer for Godda), Additional Chief Medical Officer (Addl. CMO), District Programme Officer United Nations International Children's Emergency Fund (UNICEF) and NRHM District Programme Manager
Mahagama CHC (the local FRU)	Mr Tarun Kumar Dey, clerk, Mr Prameswar Prasad Chowdhury Data Entry Assistant and nurses in charge of maternity ward, labour room and other staff (Medical Officer in Charge Dr. Tarun Kumar Mishra has been in charge since 2007 but was on leave)
Frontline worker	One *Sahiya* (Accredited Social Health Activist in Jharkhand) was interviewed

Annex Two

Civil Society Meeting in SDC Ranchi – afternoon of 20th Nov 2013

Report by Devika Biswas

On 20-11-2013, The NAMHHR fact finding team called a meeting of civil society at SDC, Ranchi to appraise them about the basic concerns of this team on maternal death and related health issues and also appraised them about the two separate committees on the issues of tribal health, one headed by Dr Abhay Bang under the MOHFW, GOI and the other under the PMO, which are seeking public opinion and suggestion to improve tribal health.

This group has chosen to visit Godda in the wake of reported maternal deaths in Parayahat and Sunderpahari blocks in Godda to study the factors responsible for the deplorable health situations of tribal communities Santhals and Pahariyas (Primitive Tribal Groups). In this connection the team had organized a Civil Society Organisations (CSO) meeting to get feedback from the participants and suggestions for inclusion of various issues that this team should explore while fact finding. A total of 20 participants from different CSOs located in Saraikela Khar Sawanm Chakardharpur, Jashedpur, Ranchi, Lohardaga, Gumla, Hazaribagh, Chatra, Ramgarh, Kodermon, Pakur, Godda, Deoghar Sahebang and Dumka, attended the meeting. The participants also shared that due to many reasons like poverty, malnutrition, lack of ANC services and an unresponsive system, maternal deaths were taking place everywhere. Further, the attitude of service providers is not very friendly. The participants shared that people had to incur out-of-pocket expenses and also loss of life due to the late arrival/non arrival of the Mamta Vahan, lack of medical staff at health facilities or delay in receiving treatment in time due to bad roads, which sometimes resulted in their deaths. This is a common occurrence in Jharkhand, but such deaths are not recorded, and therefore Maternal Death Reviews are not conducted. In cases where MDRs are done, it is more as a routine exercise, and the underlying causes are not recorded or addressed. The poorest of poor, weak and socially and economically disadvantaged groups suffer the most. Maternal deaths are under reported everywhere and people (communities) do not organise themselves to raise voices of protest. Even civil society in Jharkhand lacks a joint and firm stand on this issue, and therefore no big campaign or voice has ever been raised so far.

The group suggested that the following issues/points be investigated while conducting FGDs with the community regarding traditional practices in the different communities: nutrition (food), age of marriage, customs and practices related to childbirth, community based practices to enhance maternal health and support, role of TBA, gender sensitivity of family members and community members, awareness level of women about maternal health at home, hospital and during migration. Then general issues such as food security and PDS system, ICDS, safe drinking water, malnutrition and anaemia, malaria, pregnancy, budgetary allocation, transport and roads and accessibility. Suggestions were given to investigate issues related to health services, such as role of ASHA, incentives for ASHAs in remote areas, quality of ANC with birth preparedness, identification of all high risk cases, preparedness for blood, EmOC, FRUs, referral and its protocol, the role of RMP and the behaviour of service providers.

The fact finding team assured the participants that the report would be prepared soon and would incorporate the suggestions that emerged from the meeting while carrying out the FGDs or discussions with health personnel/ providers.

Participant List

	Name	Organization
1.	Devika Biswas	Health-Watch Forum, Bihar/Jharkhand
2.	Kalyani K.Meena	Prerana Bharati, Deoghar
3.	Silwanti Nag	Mahila Utprerna Kendra, Hazaribag
4.	Nagendra Kumar	
5.	Hussain Imam Fatmi	SPARK, Ranchi
6.	Indramani Sahu	SAMARPAN, Koderma
7.	Sachi Kumari	CSS, Ranchi
8.	Puspa Sharma	Srijan Foundation
9.	Bina Soni	Anupam Mahila Chetna Samiti, Hazaribag
10.	Samit Kumar	Restless Development, Deoghar
11.	Zia	EKJUT, Ranchi
12.	Vikas	
13.	Priyasheela	SAHELI Adhayan Kendra, Sahebganj
14.	Praveer Peter	SOLIDARITY Centre/GLRE, Sarnatoli Kadru
15.	Vasavi Kiro	HEDAN and TORANG Trust, Ranchi
16.	Mansoor Bakht	SHARE, Ranchi
17.	Shahid Naseem	SHARE, Ranchi
18.	Jashodhara Dasgupta	SAHAYOG, UP
19.	Abhijit Das	Centre for Health and Social Justice, Delhi
20.	Ajay Lal	SATHI, Madhya Pradesh